Transition of Care Benefits Application

Instructions for Completing and Submitting this Application

To be eligible for transition of care benefits, you must be enrolled in a benefit plan administered by MVP Health Care®. To apply for these benefits, complete Sections 1 of this Application. Print both pages of the Application and ask your current non-MVP participating physician to complete Section 2. You or the physician should submit the completed Application and copies of relevant medical records to MVP via the fax number or mailing address indicated on page 2 of the Application.

If more than one non-MVP participating physician is involved in your case, please complete and submit a separate Application for each physician.

For the best experience, use Adobe Acrobat Reader to complete and print the Application.

Who should use this application?

Use this application for medically necessary transitional care if you are:

- **Receiving care from a non-participating physician**—if you are a new MVP member who is receiving treatment for a life threatening, degenerative, or disabling condition from a non-participating provider, you may be eligible for 60 days of Transition of Care Benefits. If you are in your second or third trimester of pregnancy, the transitional period includes delivery and postpartum care related to the delivery
- **Receiving care from a physician who has left the MVP provider network**—If your provider has left the provider network and you are a current member receiving an active course of treatment or are scheduled for non-elective surgery, you may be eligible for 90 days of transitional care from the date your physician left the network. If you are pregnant, the transitional period includes delivery and postpartum care related to the delivery

About Medically Necessary Transitional Care

If the MVP Medical Director determines transitional care is medically necessary under the terms of the benefit plan, MVP will approve specific treatment, by specified non-MVP participating physician(s) for a specific period of time. It is also necessary for the non-MVP physician to agree to all of the following:

- Accept MVP's payment in full
- Provide MVP with medical information about your care
- Follow MVP policies and procedures

These services are subject to eligibility and coverage limitations at the time medical care is administered. Please refer to your plan documents, such as your Member Handbook, Evidence of Coverage, or Certificate of Coverage for further details.

Transition of Care Benefits Application

Complete and submit this application to request treatment by a provider who does not participate in the MVP Health Care® network. This is a two-page form. See the Application cover page for more information about when to use form, as well as instructions for completing and submitting this Application.

Section 1: Subscriber, Member, and Transition/Care Information

This Section is to be completed by the Subscriber/Member applying for transitional care benefits.

MVP Subscriber Name	**MVP Subscriber** ID No.	Home Phone No.
Employer Name	Plan Effective Date	Work Phone No.

MVP Subscriber Street Address	City	State	Zip Code

Member Applying for Care Name	Date of Birth	Relationship to Subscriber
		☐ **Self** ☐ **Spouse** ☐ **Dependent**

Is the Member applying for care currently covered by any of the following? ☐ **Medicare** ☐ **Medicaid** ☐ **Other Insurance**

Is the Member applying for care currently pregnant?	☐ **Yes**	☐ **No**
Is the Member applying for care currently undergoing a course of treatment?	☐ **Yes**	☐ **No**
Is the Member applying for care currently undergoing treatment for cancer?	☐ **Yes**	☐ **No**
Is the Member applying for care currently undergoing treatment for a bone fracture?	☐ **Yes**	☐ **No**
Has the Member applying for care been hospitalized within the past six months?	☐ **Yes**	☐ **No**
Is the Member applying for care scheduled for, or has had surgery within the past six weeks?	☐ **Yes**	☐ **No**
Does the Member applying for care have an appointment with the doctor prior to the effective date of coverage, or within 30 days after?	☐ **Yes**	☐ **No**

If you answered *Yes* to any of the questions above, please have your non-MVP participating physician complete **Section 2** of this Application and return it with any pertinent medical records to MVP to the fax number or address indicated above.

If you answered *No* to all of the questions above, please contact the MVP Member Services/Customer Care Center at the number on the back of your MVP Member ID card for assistance identifying an MVP network physician for an evaluation.

Member's Authorization to Release Records

I authorize all physicians and other medical professionals or institutions to provide information to MVP Health Care concerning medical care, advice, treatment, or supplies for the MVP Member named above. This information will be used to determine the Member's eligibility for Transition of Care benefits under the new plan.

The parties agree that this Application may be electronically signed. The parties agree that an electronic signature appearing on this Application is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Member's Signature, or Parent or Guardian's Signature if Member is a Minor *Signature Date*

Print the Application

Continued on page 2.

Subscriber Name *Subscriber ID No.*

Section 2: Physician and Treatment/Care Information

This Section is to be completed by the Non-MVP participating physician treating the MVP Member.

Non-MVP Participating Physician Name | Tax ID No. | Phone No.

Street Address | City | State | Zip Code

MVP Member's Last Visit Date | Next Scheduled Appointment Date | Visit Frequency | Expected Length of Treatment

Diagnosis

If the Member is pregnant, what is the expected date of delivery?

Is treatment for an exacerbation of a previous injury or chronic condition? ☐ **Yes** ☐ **No**

Current Treatment Comments

The parties agree that this Application may be electronically signed. The parties agree that an electronic signature appearing on this Application is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Physician's Signature *Signature Date*

Return both pages of this completed Application and any pertinent medical records to MVP.

- By fax: **1-800-280-7346**
- By mail to: **ATTN UM DEPT PROSPECTIVE REVIEW**
  MVP HEALTH CARE
  PO BOX 2207
  SCHENECTADY NY 12301-2207

FOR INTERNAL MVP USE ONLY

Transition of Care Benefits are ☐ **Approved.** ☐ **Not Approved.**

MVP Medical Director *Signature* *Name (print)* *Date*

Comments